January 30, 2004

# HOUSE BILL No. 1445

DIGEST OF HB 1445 (Updated January 27, 2004 5:41 pm - DI 77)

**Citations Affected:** IC 12-15.

**Synopsis:** Prior authorization limitation on asthma drugs. Prohibits the office of Medicaid policy and planning and a managed care organization from requiring prior authorization on a drug that is used: (1) in an outpatient setting; and (2) for the treatment of a life threatening acute bronchial spasm condition.

**Effective:** July 1, 2004.

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## Behning, Becker, Hasler, Brown C

January 20, 2004, read first time and referred to Committee on Public Health.
January 29, 2004, reported — Do Pass; referred to Committee on Ways and Means pursuant to Rule 127.

January 30, 2004

Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

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# HOUSE BILL No. 1445

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

*Be it enacted by the General Assembly of the State of Indiana:*

SECTION 1. IC 12-15-35-46, AS ADDED BY P.L.231-1999, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 46. (a) This section applies to a managed care organization that enters into an initial contract with the office to be a Medicaid managed care organization after May 13, 1999.

(b) Before a Medicaid managed care organization described in subsection (a) implements a formulary, the managed care organization shall submit the formulary to the office at least thirty-five (35) days before the date that the managed care organization implements the formulary for Medicaid recipients.

(c) The office shall forward the formulary to the board for the board's review and recommendation.

(d) The office shall provide at least thirty (30) days notification to the public that the board will review a Medicaid managed care organization's proposed formulary at a particular board meeting. The notification shall contain the following information:

(1) A statement of the date, time, and place at which the board

meeting will be convened.

(2) A general description of the subject matter of the board meeting.

(3) An explanation of how a copy of the formulary to be discussed may be obtained.

The board shall meet to review the formulary at least thirty (30) days but not more than sixty (60) days after the notification.

(e) In reviewing the formulary, the board shall do the following:

(1) Make a determination, after considering evidence and credible information provided to the board by the office and the public, that the use of the formulary will not:

(A) impede the quality of patient care in the Medicaid program; or

(B) increase costs in other parts of the Medicaid program, including hospital costs and physician costs.

(2) Make a determination that:

(A) there is access to at least two (2) alternative drugs within each therapeutic classification, if available, on the formulary;

(B) a process is in place through which a Medicaid member has access to medically necessary drugs; and

(C) the managed care organization otherwise meets the requirements of IC 27-13-38.

(f) The board shall consider:

(1) health economic data;

(2) cost data; and

(3) the use of formularies in the non-Medicaid markets;

in developing its recommendation to the office.

(g) Within thirty (30) days after the board meeting, the board shall make a recommendation to the office regarding whether the proposed formulary should be approved, disapproved, or modified.

(h) The office shall rely significantly on the clinical expertise of the board. If the office does not agree with the recommendations of the board, the office shall, at a public meeting, discuss the disagreement with the board and present any additional information to the board for the board's consideration. The board's consideration of additional information must be conducted at a public meeting.

(i) Based on the final recommendations of the board, the office shall approve, disapprove, or require modifications to the Medicaid managed care organization's proposed formulary. The office shall notify the managed care organization of the office's decision within fifteen (15) days of receiving the board's final recommendation.

(j) The managed care organization must comply with the office's

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decision within sixty (60) days after receiving notice of the office's decision.

(k) Notwithstanding the other provisions of this section, the office may temporarily approve a Medicaid managed care organization's proposed formulary pending a final recommendation from the board.

**(l) A managed care organization may not require prior authorization for a drug that is used:**

**(1) in an outpatient setting; and**

**(2) for the treatment of a life threatening acute bronchial spasm condition.**

SECTION 2. IC 12-15-35.5-3, AS ADDED BY P.L.6-2002, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 3. (a) Except as provided in ~~subsection~~ **subsections** (b) **and (d),** the office may establish prior authorization requirements for drugs covered under a program described in section 1(a) of this chapter.

(b) The office may not require prior authorization for the following single source or brand name multisource drugs:

(1) A drug that is classified as an antianxiety, antidepressant, or antipsychotic central nervous system drug in the most recent publication of Drug Facts and Comparisons (published by the Facts and Comparisons Division of J.B. Lippincott Company).

(2) A drug that, according to:

(A) the American Psychiatric Press Textbook of Psychopharmacy;

(B) Current Clinical Strategies for Psychiatry;

(C) Drug Facts and Comparisons; or

(D) a publication with a focus and content similar to the publications described in clauses (A) through (C);

is a cross-indicated drug for a central nervous system drug classification described in subdivision (1).

(3) A drug that is:

(A) classified in a central nervous system drug category or classification (according to Drug Facts and Comparisons) that is created after the effective date of this chapter; and

(B) prescribed for the treatment of a mental illness (as defined in the most recent publication of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders).

(c) Except as provided under section 7 of this chapter, a recipient enrolled in a program described in section 1(a) of this chapter shall have unrestricted access to a drug described in subsection (b).

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**(d) The office may not require prior authorization for a drug that is used:**

**(1) in an outpatient setting; and**

**(2) for the treatment of a life threatening acute bronchial spasm condition.**

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1445, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

BROWN C, Chair

Committee Vote: yeas 12, nays 0.

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